**U.S. Department of Labor**

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

**Issue date: 03Jul2002**

| | | |
|---|---|---|
| ***In the Matter of:*** | : | |
| | : | |
| EARNEL P. LUSK, | : | Case No: 2000-BLA-546 |
| Claimant, | : | |
| | : | |
| v. | : | |
| | : | |
| STONECOAL BRANCH MINING, INC., | : | |
| Employer, | : | |
| | : | |
| and | : | |
| | : | |
| DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, | : | |
| Party-in-Interest | : | |

S.F. Raymond Smith, Esquire
For the Claimant

Robert Weinberger, Esquire
For the Employer

Francine A. Serafin, Esquire
For the Director, OWCP

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

**DECISION AND ORDER ON REMAND--DENYING BENEFITS**

Statement of the Case

This case was remanded to this tribunal by unpublished decision and order of the Benefits Review Board (the "Board") dated December 31, 2001, vacating this tribunal's December 27, 2000 denial of benefits and instructing it on remand to consider whether Claimant has established the existence of complicated pneumoconiosis. The Board affirmed, as unchallenged on appeal, this tribunal's findings of at least twenty-four years of coal mine employment, the existence of simple

coal workers' pneumoconiosis arising out of coal mine employment at §§718.202(a)(1), (a)(4), and 718.203(b), no pneumoconiosis at §718.202(a)(2), and no total respiratory disability at §718.204(c) (pre-amended regulations).

This proceeding involves a first claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 *et seq.* ("the Act"), and the regulations promulgated thereunder.[1] Since this claim was filed after March 31, 1980, Part 718 applies. Because the Claimant was last employed in the coal industry in West Virginia, the law of the Fourth Circuit of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*).

## Issue

Whether the Claimant has complicated pneumoconiosis as defined in §718.304, and, is therefore, entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis?

## Findings of Fact and Conclusions of Law

*Background, Length of Coal Mine Employment, and Smoking History*

Claimant, Earnel P. Lusk, was born on January 20, 1942, and possesses a sixth grade education. For the purposes of augmentation of benefits, Claimant has a dependent wife, Eleanor Lusk. (D-1) Claimant completed at least 24 years of qualifying coal mine employment. Claimant last worked as a coal miner in August 1998 as a roof bolter for Stonecoal Branch Mining, Inc. (D-1; Tr.7, 10-11). Claimant also worked in a sawmill for at least fourteen years (D-12; E-1). Claimant smoked less than one pack of cigarettes per day for approximately eleven years until 1969 (D-12; E-1; Tr. 13).

*Medical Evidence Related to the Issue of Complicated Pneumoconiosis*

*X-ray Evidence*[2]

---

[1]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "D-"; Claimant's Exhibits are denoted "C-"; Employer's Exhibits are denoted "E-"; and citations to the hearing transcript are denoted "Tr."

[2] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis. The credentials of Drs. Patel and Ahmed are not of record. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. This tribunal also takes judicial notice that Drs. Patel, Ahmed, and Aycoth are listed as B-readers on the list of NIOSH Approved Readers. *See Maddaleni v.*

| Exh. No. | Date of X-ray | Date of Reading | Physician/ Qualifications | Interpretation |
|---|---|---|---|---|
| D-14 | 3/1/97 | 10/25/99 | Patel B/R | Compared to 10/1/99 film: there is interval change; the apparent faint density in the right upper lung zone periphery has developed in the interval.<br><br>Impression: 1. New faint coin density in the right upper lobe periphery. Rule out neoplasia; 2. Mild chronic obstructive pulmonary disease; 3.Classifiable pneumoconiosis; 4. CT scan of chest is appropriate in further investigation. |
| D-14 | 10/1/99 | 10/12/99 | Patel B/R | 1/1, t/t; emphysema; right upper zone coin density 1.2 cm. indeterminate granuloma neoplasia; comparison with previous chest x-ray or CT chest; mild chronic obstructive pulmonary disease |
| D-15 | 10/1/99 | 11/23/99 | Navani B/R | 1/0, q/p |
| E-1 | 1/19/00 | 3/5/00 | Zaldivar B | 0/0 |
| C-1 | 1/19/00 | 8/30/00 | Aycoth B | 2/1, q/t |
| C-2 | 1/19/00 | 8/28/00 | Ahmed B/R | 1/2, q/t, emphysema |

*Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990). Dr. Aycoth's professional credentials other than his status as a B-reader are not of record and could not be ascertained.

CT Scan Evidence

| Exh. No. | Date of CT Scan | Date of Reading | Physician/ Qualifications | Interpretation |
|---|---|---|---|---|
| C-1 | 12/22/99 | 8/30/00 | Aycoth B | 1. Complicated pneumoconiosis category A, 2/1, q/t. There is a faint 1-cm. right upper lobe nodule with small bilateral pleural effusions.<br><br>2. A 5-6 cm, large mass of liver. |
| C-2 | 12/22/99 | 8/28/00 | Ahmed B/R | 1. 1.5 cm. speculated nodule right upper lobe could be complicated pneumoconiosis A or a neoplasm. Biopsy or comparison with old CT helpful.<br><br>2. Lesion left lobe of liver needs further evaluation to rule out neoplasm. |

*Physicians' Opinions*[3]

Dr. D.L. Rasmussen, board-certified in internal medicine, examined Claimant on October 1,1999 and prepared a report thereof dated October 30, 1999. (D-12). Dr. Rasmussen noted that the Claimant was employed for fifteen to sixteen years in a saw mill with exposure to oak, maple, and pine with considerable dust. He recorded a coal mine employment history of approximately twenty-four and one-half years, lastly as a roof bolter. Dr. Rasmussen performed an examination and specified medical tests, and reviewed an x-ray read as positive by Dr. Patel. Dr. Rasmussen noted that Claimant's ventilatory studies, while not qualifying, revealed a slight obstructive insufficiency and only a minimal loss of respiratory function. Dr. Rasmussen also obtained non-qualifying blood gas results. The doctor opined that based upon Claimant's coal mine employment and the positive x-ray, it is "medically reasonable to conclude that he has coalworkers' pneumoconiosis which arose from coal mine employment." Dr. Rasmussen opined that Claimant retains the pulmonary capacity to perform his last coal mine job, and that the minimal impairment Claimant has is due to his coal dust exposure. With regard to Dr. Patel's interpretation of the October 1, 1999 x-ray, Dr. Rasmussen noted his finding of a right upper zone coin density and that Dr. Patel had subsequently reviewed a

[3]The credentials of Dr. Rasmussen are not of record. However, this tribunal takes judicial notice that his relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

March 1, 1997 x-ray which failed to reveal a right upper zone density. Dr. Rasmussen ended his report by noting that the Claimant and his physician were informed about the abnormal density in the right upper lobe.

Dr. George Zaldivar, board certified in internal medicine, pulmonary disease, and sleep disorder medicine, examined the Claimant on January 19, 2000 and prepared a report thereof dated March 7, 2000. (E-1). The doctor interpreted an x-ray as negative for pneumoconiosis, recorded Claimant's medical and social histories, examined Claimant, and performed specified medical tests. Dr. Zaldivar recorded a twenty-four and one-half year coal mine employment history, lastly as a roof bolter. He also noted that Claimant had worked in a sawmill for fourteen years. The Claimant informed Dr. Zaldivar that he began smoking at the age of fifteen or sixteen and smoked less than one pack of cigarettes per day, quitting thirty years prior to the examination. Dr. Zaldivar obtained non-qualifying results in the pulmonary function studies and blood gas studies that he performed. Dr. Zaldivar summarized his findings as mild irreversible airway obstruction. The doctor noted that there were no medical findings consistent with a diagnosis of pneumoconiosis and no medical evidence of pulmonary impairment. Dr. Zaldivar opined that Claimant is capable, from a pulmonary standpoint, of performing his usual coal mine work.

*Section 718.304--The Irrebuttable Presumption of Total Disability Due to Pneumoconiosis*

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by or that the miner's death was due to pneumoconiosis if the miner is suffering or suffered from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three methods by which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs, or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis, but rather require the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*); *see also Dennis E. Keene v. G & A Coal Co.*, BRB No. 96-1689 BLA-A (September 27, 1996) (*unpublished*).

The Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250 (4th Cir. 2000), affirmed its position in *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999) and adopted the Third Circuit's holding in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981), that the three prongs of §718.304 are intended to describe a single, objective

condition. *Id.* at 255. Accordingly, as each prong requires a separate analysis, the Court held, "one must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Scarbro at 255-256; Blankenship* at 243; *see also Jones Laughlin Steel Corp.* at 16.

In *Blankenship*, the Fourth Circuit elaborated the required equivalency determination, stating:

> Because prong (A) sets up an entirely objective scientific standard, it provides the mechanism for determining equivalencies under prong (B) or prong (C). In prong (A), Congress mandated that the condition that triggers the irrebuttable presumption is one that creates, on an x-ray, at least one opacity greater than one centimeter in diameter. When that condition is diagnosed by biopsy rather than x-ray, it must therefore be determined whether the biopsy results show a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. That is to say, "massive lesions," as described in prong (B), are lesions that when x-rayed, show as opacities greater than one centimeter in diameter.

*Blankenship* at 243. The Court stated that "the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader." *Scarbro* at 256.

The Board found that this tribunal incorrectly stated that the record contained no evidence of complicated pneumoconiosis and failed to consider all relevant evidence in the record as required by the Administrative Procedure Act. *See* 5 U.S.C §557(c)(3)(A), as incorporated into the Act by 30 U.S.C. §932(a) by means of 33 U.S.C. §919(d) and 5 U.S.C. §554(c)92); *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162 (1989); *Tenney v. Badger Coal Co.*, 7 BLR 1-589, 1-591 (1984). Therefore, on remand, this tribunal must consider whether Claimant has established the existence of complicated pneumoconiosis. Additionally, in evaluating the CT scan evidence at §718.304(c), the Board explicitly instructed this tribunal, in accordance with *Scabro* and *Blankenship,* to render an equivalency determination, *i.e.* whether the opacities found on the CT scan interpretations would be equivalent to an opacity greater than one centimeter in diameter on an x-ray.

*X-ray Evidence under Prong (a) of §718.304*

The record contains evidence of three x-rays interpreted by five physicians for a total of six interpretations. Of those five physicians, two were B-readers, and three were dually qualified board-certified radiologists and B-readers. Prong (a) of §718.304 dictates that the presumption is established by x-rays yielding one or more large opacities greater than 1.0 centimeter in diameter that would be classified in Category A, B or C in the ILO-U/C International Classification of Radiographs of the Pneumoconioses. None of the five physicians interpreted the films as positive for complicated pneumoconiosis, Category A. Dr. Patel, a dually qualified board-certified

radiologist and B-reader, interpreted two films, the March 1, 1997 film and the October 1, 1999 film. While Dr. Patel identified a 1.2 centimeter "coin density" in the right upper lung zone in the October 1, 1999 film, and also identified evidence of simple coal workers' pneumoconiosis, Dr. Patel did not diagnose complicated pneumoconiosis. Instead, he addressed the need to rule out granuloma or neoplasia by review of previous chest x-rays or CT scans (D-14). Subsequently, Dr. Patel reviewed Claimant's March 1, 1997 chest-x-ray, comparing it to the October 1, 1999 film, and concluded that the density had developed during the two and one-half year interval between the taking of the two films. Based on his findings, Dr. Patel continued to suggest the need to rule out neoplasia. Significantly, he did not indicate that the density was evidence of complicated pneumoconiosis. (D-14). Dr. Patel's x-ray interpretations weigh against a finding of complicated pneumoconiosis and suggest that some disease process other than pneumoconiosis is responsible for the relatively sudden appearance of the large density in the Claimant's right upper lung. Accordingly, the evidence under prong (a) of 718.304 does not establish the existence of complicated pneumoconiosis.

*Biopsy and/or Autopsy Evidence under Prong (b)*

The record contains no biopsy evidence, and, therefore, Claimant cannot establish the existence of complicated pneumoconiosis under this prong.

*Diagnosis by Other Equivalent Means under Prong (c)*

Under prong (c), the irrebuttable presumption may be invoked where the miner suffered from a chronic lung disease which when diagnosed by means other than those described in prongs (a) and (b) would be a condition which could reasonably be expected to yield the massive lesions described in prongs (a) and (b). The language indicates that the diagnosis need not actually identify the existence of massive lesions. Instead, it is the disease process behind the formation of massive lesions which must be diagnosed, that disease process being complicated pneumoconiosis. S*ee Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). In this case, the CT scan evidence falls under prong (c). *See Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

Two physicians interpreted the December 22, 1999 CT scan. Dr. Ahmed, board-certified in diagnostic radiology, identified a 1.5 centimeter "speculated nodule" in the Claimant's right upper lobe which he opined "could be complicated pneumoconiosis A or a neoplasm." (C-2). Dr. Ahmed opined that biopsy or comparison with an old CT scan would be helpful. Additionally, Dr. Ahmed noted that further evaluation was required of a lesion in the Claimant's liver to also rule out neoplasm. (C-2). This tribunal notes that Dr. Ahmed also interpreted, on that same day, the Claimant's January 19, 2000 chest-x-ray and neither identified the 1.5 centimeter nodule nor diagnosed complicated pneumoconiosis (C-2). Accordingly, Dr. Ahmed's interpretation of the Claimant's CT scan does not establish the existence of complicated pneumoconiosis because he deferred forming a definitive conclusion based on the need for pathological or further CT scan correlation, in effect making his opinion equivocal. Moreover, Dr. Ahmed's finding of an additional

lesion which he speculated was also a neoplasm, and failure to identify the lesion on Claimant's chest-x-ray permits the inference that Dr. Ahmed strongly contemplated that a disease process causing neoplasms, as opposed to one related to the Claimant's history of coal dust inhalation, was at work in the Claimant's system. It also militates against equivalency with prong (a).

Dr. Aycoth, whose credentials other than his status as a B-reader are unascertainable, identified in the CT scan a "faint 1-cm. right upper lobe nodule with small bilateral effusions" which he opined was evidence of complicated pneumoconiosis, Category A. Dr. Aycoth also identified a "large 5-6 cm. liver mass." (C-1). However, upon review of the January 19, 2000 x-ray on that same day, Dr. Aycoth did not identify the 1 centimeter nodule or any other mass consistent with complicated pneumoconiosis (C-1). Both Dr. Aycoth's and Dr. Ahmed's opinions indicate that the nodule in the Claimant's right upper lung is not equivalent to an opacity greater than one centimeter in diameter on an x-ray. Neither identified the nodule in his interpretation of the Claimant's January 19, 2000 x-ray, which was taken one month after the CT scan.

Dr. Navani, a dually qualified board-certified radiologist and B-reader, and Dr. Zaldivar, a B-reader, also did not observe a massive lesion upon interpretation of the Claimant's x-rays (D-15; E-1). Only Dr. Patel was able to identify the nodule on x-ray interpretation. However, he did not opine that it was related to, or was a manifestation of, complicated pneumoconiosis. Because the majority of the physicians did not identify the nodule in the Claimant's right upper lung as an opacity greater than one centimeter in diameter on the Claimant's x-ray, and because the only physician who did identify the nodule as such an opacity did not relate it to pneumoconiosis, this tribunal finds that the nodule found to measure between 1 and 1.5 centimeter on CT scan is not equivalent to a 1.0 centimeter or greater pneumoconiotic opacity on an x-ray. Furthermore, because no physician opined with regard to what size of a lesion on CT scan would be equivalent to a 1.0 centimeter opacity on x-ray, this tribunal cannot determine equivalency in this case. Accordingly, Dr. Aycoth's CT scan interpretation, and the evidence under this prong in its entirety, does not establish the existence of complicated pneumoconiosis.

*Conclusion under §718.304*

Since the evidence under the three prongs of §718.304 does not establish the existence of complicated pneumoconiosis, the Claimant is not entitled to invoke the irrebuttable presumption. While x-ray evidence adduced from Dr. Patel considered in isolation might have met the standard set forth in prong (a), the probative force of that evidence was vitiated by evidence that the lesion had developed quickly and was likely due to an intervening pathology other than pneumoconiosis. The CT scan evidence supported the x-ray evidence in that, while the physicians were able to identify a lesion of comparable size to a lesion of complicated pneumoconiosis, Dr. Ahmed and Dr. Patel agreed that the lesion was possibly due to a neoplasm-causing disease process, and, therefore, unrelated to the Claimant's former coal mine employment. Dr. Aycoth's opinion is less persuasive because he has not been proven to be a board-certified radiologist, and he did not in any event identify an opacity of greater than one centimeter upon interpretation of the Claimant's most recent x-ray. Accordingly, this tribunal finds that, because the preponderance of the evidence does not indicate that the lesion in the Claimant's right upper lung is a manifestation of complicated

pneumoconiosis, or that it would have produced an opacity greater than one centimeter on x-ray, Claimant is not entitled to benefits under the Act.

Attorney's Fee

The award of an attorney's fee under the Act will be approved only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services of an attorney rendered to the Claimant in pursuit of this claim.

**ORDER**

The claim of Earnel P. Lusk for benefits under the Act is denied.

A

EDWARD TERHUNE MILLER
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS**: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20001.